FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0045666

Facility Name: CAPITOL CARE CENTER

Address: 555 WEST CARPENTER (Number) SPRINGFIELD (City) 62702 (Zip Code)

County: SANGAMON

Telephone Number: (217) 525-1880 **Fax #** (217) 525-7762

IDPA ID Number: 371414170001

Date of Initial License for Current Owners: 10/01/01

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: DARRYL BUEKER **Telephone Number:** (417) 865-8701

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) DARRYL BUEKER, CPA
(Firm Name & Address) BKD, LLP
P. O. Box 1190, Springfield, MO 65801-1190
(Telephone) (417) 865-8701 Fax # (417) 865-0682

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	251	Skilled (SNF)	251	91,866	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	251	TOTALS	251	91,866	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	56,812	3,079	14,417	74,308	8
9	SNF/PED					9
10	ICF		6,655		6,655	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	56,812	9,734	14,417	80,963	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.13%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/ 01 / 01

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/01/01 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 251 and days of care provided 14,417

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	312,155	49,075	12,491	373,721		373,721		373,721			1
2	Food Purchase		353,023		353,023		353,023	(191)	352,832			2
3	Housekeeping	151,424	35,701		187,125		187,125		187,125			3
4	Laundry	172,756	34,056		206,812		206,812		206,812			4
5	Heat and Other Utilities			208,772	208,772		208,772	2,447	211,219			5
6	Maintenance	143,276		115,578	258,854		258,854	3,201	262,055			6
7	Other (specify):*											7
8	**TOTAL General Services**	779,611	471,855	336,841	1,588,307		1,588,307	5,457	1,593,764			8
	B. Health Care and Programs											
9	Medical Director			26,088	26,088		26,088		26,088			9
10	Nursing and Medical Records	2,907,350	229,883	5,529	3,142,762		3,142,762		3,142,762			10
10a	Therapy	46,097		901,770	947,867		947,867		947,867			10a
11	Activities	107,640	11,481	2,177	121,298		121,298		121,298			11
12	Social Services	63,902	30	2,023	65,955		65,955		65,955			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,124,989	241,394	937,587	4,303,970		4,303,970		4,303,970			16
	C. General Administration											
17	Administrative	101,643		787,020	888,663		888,663	(444,524)	444,139			17
18	Directors Fees											18
19	Professional Services			105,366	105,366		105,366	16,279	121,645			19
20	Dues, Fees, Subscriptions & Promotions			55,608	55,608		55,608	(36,481)	19,127			20
21	Clerical & General Office Expenses	516,057	51,908	99,413	667,378		667,378	41,757	709,135			21
22	Employee Benefits & Payroll Taxes			830,066	830,066		830,066	(21,650)	808,416			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,638	6,638		6,638	908	7,546			24
25	Other Admin. Staff Transportation			60,288	60,288		60,288	2,523	62,811			25
26	Insurance-Prop.Liab.Malpractice			214,955	214,955		214,955	795	215,750			26
27	Other (specify):*							22,757	22,757			27
28	**TOTAL General Administration**	617,700	51,908	2,159,354	2,828,962		2,828,962	(417,636)	2,411,326			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,522,300	765,157	3,433,782	8,721,239		8,721,239	(412,179)	8,309,060			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number CAPITOL CARE CENTER #0045666 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			59,682	59,682		59,682	(11,810)	47,872			30
31	Amortization of Pre-Op. & Org.							262	262			31
32	Interest			39,001	39,001		39,001	5,295	44,296			32
33	Real Estate Taxes			123,998	123,998		123,998		123,998			33
34	Rent-Facility & Grounds			830,261	830,261		830,261	9,740	840,001			34
35	Rent-Equipment & Vehicles			186,889	186,889		186,889	5,126	192,015			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,239,831	1,239,831		1,239,831	8,613	1,248,444			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		468,547		468,547		468,547		468,547			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			137,800	137,800		137,800		137,800			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		468,547	137,800	606,347		606,347		606,347			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,522,300	1,233,704	4,811,413	10,567,417		10,567,417	(403,566)	10,163,851			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 Report Period Beginning: 01/01/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(21,222)	30		9
10	Interest and Other Investment Income	(1,323)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(191)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(22,425)	21		18
19	Entertainment				19
20	Contributions	(10,300)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(35,371)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(13,997)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(54,781)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (159,610)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(243,956)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (243,956)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (403,566)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

CAPITOL CARE CENTER

ID# 0045666

Report Period Beginning: 01/01/04

Ending: 12/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Bank fees	$ (2,074)	21	1
2	Taxes-General	(757)	21	2
3	Entertainment Expense	(21,650)	22	3
4	Lobbying Expense	(4,316)	20	4
5	Management Fees	(25,002)	17	5
6	Real Estate Taxes	(4,634)	33	6
7	Vehicle reimbursement	3,652	35	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(54,781)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 Report Period Beginning: 01/01/04 Ending: 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(191)	0	0	0	0	0	0	0	0	0	0	(191)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	2,447	0	0	0	0	0	0	0	0	2,447	5
6	Maintenance	0	0	3,201	0	0	0	0	0	0	0	0	3,201	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(191)	0	5,648	0	0	0	0	0	0	0	0	5,457	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(25,002)	0	(419,522)	0	0	0	0	0	0	0	0	(444,524)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	16,279	0	0	0	0	0	0	0	0	16,279	19
20	Fees, Subscriptions & Promotions	(39,687)	0	3,206	0	0	0	0	0	0	0	0	(36,481)	20
21	Clerical & General Office Expenses	(49,553)	0	91,310	0	0	0	0	0	0	0	0	41,757	21
22	Employee Benefits & Payroll Taxes	(21,650)	0	0	0	0	0	0	0	0	0	0	(21,650)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	908	0	0	0	0	0	0	0	0	908	24
25	Other Admin. Staff Transportation	0	0	2,523	0	0	0	0	0	0	0	0	2,523	25
26	Insurance-Prop.Liab.Malpractice	0	0	795	0	0	0	0	0	0	0	0	795	26
27	Other (specify):*	0	0	22,757	0	0	0	0	0	0	0	0	22,757	27
28	**TOTAL General Administration**	(135,892)	0	(281,744)	0	0	0	0	0	0	0	0	(417,636)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(136,083)	0	(276,096)	0	0	0	0	0	0	0	0	(412,179)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(21,222)	0	9,412	0	0	0	0	0	0	0	0	(11,810)	30
31	Amortization of Pre-Op. & Org.	0	0	262	0	0	0	0	0	0	0	0	262	31
32	Interest	(1,323)	0	6,618	0	0	0	0	0	0	0	0	5,295	32
33	Real Estate Taxes	(4,634)	0	4,634	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	9,740	0	0	0	0	0	0	0	0	9,740	34
35	Rent-Equipment & Vehicles	3,652	0	1,474	0	0	0	0	0	0	0	0	5,126	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(23,527)	0	32,140	0	0	0	0	0	0	0	0	8,613	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(159,610)	0	(243,956)	0	0	0	0	0	0	0	0	(403,566)	45

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V				$			$	$	1
2	V									2
3	V									3
4	V									4
5	V									5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$			$	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Home Office Expense	$ 462,000	Platinum Health Care, LLC	100.00%	$	$ (462,000)	15
16	V	5	Utilities		Platinum Health Care, LLC	100.00%	2,447	2,447	16
17	V	6	Repairs & Maintenance		Platinum Health Care, LLC	100.00%	3,201	3,201	17
18	V	17	Administrative Salary		Platinum Health Care, LLC	100.00%	42,478	42,478	18
19	V	19	Professional Fees		Platinum Health Care, LLC	100.00%	16,279	16,279	19
20	V	20	Fees, Subscriptions		Platinum Health Care, LLC	100.00%	3,157	3,157	20
21	V	21	Clerical Salaries		Platinum Health Care, LLC	100.00%	68,485	68,485	21
22	V	21	Office Expenses		Platinum Health Care, LLC	100.00%	22,825	22,825	22
23	V	24	Education & Seminars		Platinum Health Care, LLC	100.00%	908	908	23
24	V	25	Travel		Platinum Health Care, LLC	100.00%	2,523	2,523	24
25	V	27	Employee Benefits		Platinum Health Care, LLC	100.00%	22,757	22,757	25
26	V	26	Insurance		Platinum Health Care, LLC	100.00%	795	795	26
27	V	30	Depreciation		Platinum Health Care, LLC	100.00%	1,324	1,324	27
28	V	34	Office Rent		Platinum Health Care, LLC	100.00%	9,740	9,740	28
29	V	35	Equipment Rental		Platinum Health Care, LLC	100.00%	1,474	1,474	29
30	V	20	Licenses & Permits		Platinum Health Care, LLC	100.00%	49	49	30
31	V	31	Amortization		Platinum Health Care, LLC	100.00%	262	262	31
32	V	30	Depreciation		Platinum Health Care, LLC	100.00%	8,088	8,088	32
33	V	32	Interest		Platinum Health Care, LLC	100.00%	6,618	6,618	33
34	V	33	Real Estate Taxes		Platinum Health Care, LLC	100.00%	4,634	4,634	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 462,000			$ 218,044	$ * (243,956)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Ben Klein	Owner	Administrative	12.50	See Attached	7	14.58%	Mgmt Fees	$ 100,006	17-03	1
2	Brian Levinson	Owner	Administrative	12.50	See Attached	11	20.83%	Mgmt Fees	100,006	17-03	2
3	Mark Shapiro	Owner	Administrative	12.50	See Attached	11	22.92%	Mgmt Fees	100,006	17-03	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 300,018		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Platinum Health Care Consultants, LLC
Street Address: 7444 Long Ave.
City / State / Zip Code: Skokie, IL 60077
Phone Number: (847) 329-4100
Fax Number: (847) 329-7652

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Patient Days	471,695	11	$ 14,258	$	80,963	$ 2,447	1
2	6	Repair & Maintenance	Patient Days	471,695	11	18,651		80,963	3,201	2
3	17	Administrative Salary	Patient Days	471,695	11	247,477	247,477	80,963	42,478	3
4	19	Professional Fees	Patient Days	471,695	11	94,841		80,963	16,279	4
5	20	Fees, Subscriptions	Patient Days	471,695	11	18,392		80,963	3,157	5
6	21	Clerical Salaries	Patient Days	471,695	11	398,996	398,996	80,963	68,485	6
7	21	Office Expenses	Patient Days	471,695	11	132,981		80,963	22,825	7
8	24	Education & Seminars	Patient Days	471,695	11	5,291		80,963	908	8
9	25	Travel	Patient Days	471,695	11	14,698		80,963	2,523	9
10	25	Travel	Direct Cost	471,695	11	483			0	10
11	27	Employee Benefits	Patient Days	471,695	11	132,583		80,963	22,757	11
12	26	Insurance	Patient Days	471,695	11	4,633		80,963	795	12
13	30	Depreciation	Patient Days	471,695	11	21,727		80,963	1,324	13
14	34	Office Rent	Patient Days	471,695	11	56,748		80,963	9,740	14
15	35	Equipment Rental	Patient Days	471,695	11	8,588		80,963	1,474	15
16	20	Licenses & Permits	Patient Days	471,695	11	288		80,963	49	16
17	31	Amortization	Patient Days	471,695	11	1,528		80,963	262	17
18	30	Depreciation	Patient Days	471,695	11	47,121		80,963	8,088	18
19	32	Interest	Patient Days	471,695	11	38,558		80,963	6,618	19
20	33	Real Estate Taxes	Patient Days	471,695	11	27,000		80,963	4,634	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,284,842	$ 646,473		$ 218,044	25

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Universal			Insurance Financing			$ 75,804	$			$ 1,774	1
2	Allocation from Platinum										6,618	2
3												3
4												4
5												5
	Working Capital											
6	Albany Bank & Trust		X	Line of Credit				1,250,000			37,227	6
7												7
8												8
9	TOTAL Facility Related						$ 75,804	$ 1,250,000			$ 45,619	9
	B. Non-Facility Related*											
10	Interest Income										(1,323)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,323)	14
15	TOTALS (line 9+line14)						$ 75,804	$ 1,250,000			$ 44,296	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #**

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 65,954	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 93,952	2
3. Under or (over) accrual (line 2 minus line 1).		$ 27,998	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 96,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 123,998	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999		8
2000		9
2001	92,074	10
2002	65,954	11
2003	93,952	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CAPITOL CARE CENTER COUNTY SANGAMON

FACILITY IDPH LICENSE NUMBER 0045666

CONTACT PERSON REGARDING THIS REPORT DARRYL BUEKER

TELEPHONE (417) 865-8701 FAX #: (417) 865-0682

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-28.0-401-018	Long Term Care Property	$ 90,875.06	$ 90,875.06
2.	14-28.0-401-006	Long Term Care Property	$ 3,076.92	$ 3,076.92
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 93,951.98	$ 93,951.98

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 Report Period Beginning: 01/01/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 61,806 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 4

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	AWNING			2001	6,950		20	348	348	1,102	9
10	SIGNS & BANNERS			2001	4,354		10	435	435	1,341	10
11	A/C			2002	505		5	101	101	238	11
12	A/C			2002	5,263		7	752	752	2,131	12
13	MASONRY RESTORATION			2002	4,098		10	410	410	1,025	13
14	CEILING WORK			2002	1,500		20	75	75	225	14
15	CEILING WORK			2002	1,835		20	92	92	260	15
16	DOORS			2002	5,665		10	567	567	1,323	16
17	INSTALL GLASS			2002	735		10	74	74	222	17
18	A/C REPAIR			2002	1,202		10	120	120	315	18
19	ELEVATOR REPAIR			2002	2,320		20	116	116	319	19
20	INSTALL GLASS			2002	550		10	55	55	147	20
21	A/C REPAIR			2002	899		10	90	90	217	21
22	FIRE SPRINKLER REPAIR			2002	1,383		10	138	138	334	22
23	WATER PUMP REPAIR			2002	1,566		10	157	157	340	23
24	WATER HEATER			2002	10,018		12	835	835	2,296	24
25	THERMOSTAT REPAIR			2002	2,287		10	229	229	649	25
26	THERMOSTAT REPAIR			2002	825		10	83	83	187	26
27	REPAIR KITCHEN EQUIP			2002	1,695		10	170	170	510	27
28	INSTALL SIGNS			2002	2,710		10	271	271	813	28
29	INSTALL SIGNS			2002	718		10	72	72	216	29
30	ACCESS CONTROL SYSTEM			2002	3,482		10	348	348	1,044	30
31	ACCESS CONTROL SYSTEM			2002	2,646		10	265	265	795	31
32	ACCESS CONTROL SYSTEM			2002	588		10	59	59	172	32
33	INSTALL SIGNS			2002	977		10	98	98	277	33
34	SHOWER & GUARD RAILS			2002	535		20	27	27	61	34
35	CALL CORDS			2002	599		20	30	30	80	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	RAIL POST	2002	$ 540	$	20	$ 27	$ 27	$ 65	37
38	CURTAIN FOR MAIN DINING ROOM	2003	849		5	170	170	269	38
39	REPLACEMENT FOR ZONAIRE	2003	5,565		20	278	278	348	39
40	FURNISH & INSTALL NEW CONDENSER	2003	1,521		20	76	76	89	40
41	A/C UNIT	2003	1,100		5	220	220	257	41
42	HOYER LIFT	2003	19,216		10	1,922	1,922	2,082	42
43	NURSES STATION REMODEL	2004	7,877		15	219	219	219	43
44	ALTERNATE FLOOR FIRE SVCS	2004	3,255		10	244	244	244	44
45	OVERHAUL 2 ELEVATORS	2004	40,080		20	1,169	1,169	1,169	45
46	CARPET	2004	9,720		5	486	486	486	46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66	Allocation from Platinum Healthcare (Bldg & Improv)			1,760		1,760		1,760	66
67									67
68									68
69				14,015			(14,015)		69
70	TOTAL (lines 4 thru 69)		$ 155,628	$ 15,775		$ 12,588	$ (3,187)	$ 23,627	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 141,469	$ 20,130	$ 21,924	$ 1,794	Various	$ 52,079	71
72	Current Year Purchases	47,804	25,538	5,708	(19,830)	Various	5,708	72
73	Fully Depreciated Assets							73
74	Platinum Healthcare LLC	76,520	16,385	7,652	(8,733)		8,864	74
75	TOTALS	$ 265,793	$ 62,053	$ 35,284	$ (26,769)		$ 66,651	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 421,421	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 77,828	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 47,872	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (29,956)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 90,278	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92			92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 Report Period Beginning: 01/01/04 Ending: 12/31/04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$ 830,261			3
4	Additions	Platinum Allocation			9,740			4
5								5
6								6
7	TOTAL				$ 840,001 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO

16. Rental Amount for movable equipment: $ 141,044 Description: See attached list
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	See attached list		$	$ 50,971	17
18					18
19					19
20					20
21	TOTAL		$	$ 50,971	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-03	hrs	$		$ 407,361	$		$ 407,361	1
2	Licensed Speech and Language Development Therapist	10a-03	hrs			92,852			92,852	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-03	hrs			401,558			401,558	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-02	# of prescrpts				440,064		440,064	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Lab & X-ray	39-02					28,483		28,483	13
14	TOTAL			$		$ 901,771	$ 468,547		$ 1,370,318	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number CAPITOL CARE CENTER **#** 0045666 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/04 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 67,634	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 450,185)	3,132,793		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	185,673		6
7	Other Prepaid Expenses	1,350		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,387,450	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	143,831		15
16	Equipment, at Historical Cost	199,395		16
17	Accumulated Depreciation (book methods)	(186,064)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Deposit/Escrow	332,481		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 489,643	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,877,093	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,312,878	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	204,554		30
31	Accrued Taxes Payable (excluding real estate taxes)	42,171		31
32	Accrued Real Estate Taxes(Sch.IX-B)	96,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	269,461		36
37	Due Others & Advance Billing	113,230		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,038,294	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,250,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,250,000	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,288,294	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 588,799	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,877,093	$	48

***(See instructions.)**

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 776,466	1
2	Restatements (describe):		2
3	**Prior Period Adjustment**	71,431	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 847,897	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(109,098)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(150,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (259,098)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 588,799	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,295,971	1
2	Discounts and Allowances for all Levels	(1,283,240)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,012,731	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,981,146	6
7	Oxygen	28,771	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,009,917	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	400	13
14	Non-Patient Meals	5	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	403,684	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	24,739	19
20	Radiology and X-Ray	706	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 429,534	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,323	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,323	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending $4,933; Misc (119)	4,814	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,814	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,458,319	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,588,307	31
32	Health Care	4,303,970	32
33	General Administration	2,828,962	33
	B. Capital Expense		
34	Ownership	1,239,831	34
	C. Ancillary Expense		
35	Special Cost Centers	468,547	35
36	Provider Participation Fee	137,800	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,567,417	40
41	**Income before Income Taxes (line 30 minus line 40)****	(109,098)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (109,098)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,913	1,950	$ 84,162	$ 43.16	1
2	Assistant Director of Nursing	6,411	7,111	165,199	23.23	2
3	Registered Nurses	5,717	6,108	133,749	21.90	3
4	Licensed Practical Nurses	57,646	63,059	1,092,832	17.33	4
5	Nurse Aides & Orderlies	130,960	138,836	1,431,407	10.31	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	1,814	1,944	25,610	13.17	7
8	Rehab/Therapy Aides	2,369	2,584	20,487	7.93	8
9	Activity Director	1,676	1,972	24,699	12.52	9
10	Activity Assistants	11,937	13,242	82,942	6.26	10
11	Social Service Workers	4,378	4,590	63,902	13.92	11
12	Dietician					12
13	Food Service Supervisor	1,838	2,217	26,356	11.89	13
14	Head Cook					14
15	Cook Helpers/Assistants	35,566	37,600	285,799	7.60	15
16	Dishwashers					16
17	Maintenance Workers	10,827	12,194	143,276	11.75	17
18	Housekeepers	17,305	19,058	151,424	7.95	18
19	Laundry	17,226	18,836	172,756	9.17	19
20	Administrator	1,905	2,032	101,643	50.02	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	25,014	26,116	516,057	19.76	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	334,502	359,449	$ 4,522,300 *	$ 12.58	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	306	$ 12,491	01-03	35
36	Medical Director	Monthly	26,088	09-03	36
37	Medical Records Consultant	18	1,369	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,160	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	15	825	11-03	44
45	Social Service Consultant	36	2,023	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	375	$ 46,956		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Cynthea Schaaf	Administrator		$ 101,643
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 101,643

B. Administrative - Other

Description	Amount
Management Fees	$ 325,020
Home Office (Adjusted out on Page 6A)	462,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 787,020
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See attached list		$ 105,366
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 105,366

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 148,404
Unemployment Compensation Insurance	159,359
FICA Taxes	341,847
Employee Health Insurance	147,257
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K	1,925
Employee Benefits	9,624
TOTAL (agree to Schedule V, line 22, col.8)	$ 808,416

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,649
Health Care Worker Background Check	
(Indicate # of checks performed)	
Licenses	1,897
Advertising & Promotions	35,371
Dues & Subscriptions	12,375
Allocation from Platinum	3,206
Less: Public Relations Expense	(35,371)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,127

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	6,638
Allocation from Platinum	908
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,546

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number CAPITOL CARE CENTER **#** 0045666 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **2,160** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **137,800**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients?
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.